



Health Alliance Medical Plans  
Attn: Illinois Pre-existing  
Insurance Plan (IPXP)  
301 S. Vine St.  
Urbana, IL 61801-3347  
1-877-210-9167

## Qualifying Pre-existing Medical Condition Certification Form

Please print all information.

The "Physician's Certification" section of this form must be completed by your physician.  
This completed form must be returned with your application.

Name: \_\_\_\_\_  
*last*                    *first*                    *middle*

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day-Time Telephone Number: \_\_\_\_\_

Primary Applicant's Signature: \_\_\_\_\_ Date (MM/DD/YY): \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date (MM/DD/YY): \_\_\_\_\_  
(if applicant is under age 18 or legally incompetent)

### Physician's Certification

Physician's Name: \_\_\_\_\_  
*last*                    *first*                    *middle*

Physician's NPI \_\_\_\_\_ The person has been my patient since (MM/DD/YY): \_\_\_\_\_

**Physician: Please indicate below, the patient's primary pre-existing medical condition. Select all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> AIDS or AIDS-Related Complex (ARC) | <input type="checkbox"/> Lupus Erythematosus Disseminate                 |
| <input type="checkbox"/> Angina Pectoris                    | <input type="checkbox"/> Metastatic Cancer                               |
| <input type="checkbox"/> Arteriosclerosis Obliterans        | <input type="checkbox"/> Multiple or Disseminated Sclerosis              |
| <input type="checkbox"/> Cerebrovascular Accident (Stroke)  | <input type="checkbox"/> Muscular Atrophy or Dystrophy                   |
| <input type="checkbox"/> Chemical Dependency                | <input type="checkbox"/> Myasthenia Gravis                               |
| <input type="checkbox"/> Cirrhosis of the Liver             | <input type="checkbox"/> Myotonia  |
| <input type="checkbox"/> Coronary Insufficiency             | <input type="checkbox"/> Paraplegia or Quadriplegia                      |
| <input type="checkbox"/> Coronary Occlusion                 | <input type="checkbox"/> Parkinson's Disease                             |
| <input type="checkbox"/> Cystic Fibrosis                    | <input type="checkbox"/> Poliomyelitis                                   |
| <input type="checkbox"/> Friedreich's Ataxia                | <input type="checkbox"/> Polycystic Kidney                               |
| <input type="checkbox"/> Hemophilia (Classical)             | <input type="checkbox"/> Severe Traumatic Brain Injury                   |
| <input type="checkbox"/> Hodgkin's Disease                  | <input type="checkbox"/> Sickle Cell Anemia                              |
| <input type="checkbox"/> Huntington's Chorea                | <input type="checkbox"/> Silicosis Pneumonconiosis (Black Lung)          |
| <input type="checkbox"/> Juvenile Diabetes                  | <input type="checkbox"/> Syringomyelia                                   |
| <input type="checkbox"/> Kidney Failure Requiring Dialysis  | <input type="checkbox"/> Wilson's Disease                                |
| <input type="checkbox"/> Leukemia                           | <input type="checkbox"/> Other (indicate diagnosis or ICD-9 Code: _____) |

I hereby certify that the responses as recorded above are full, complete and true to the best of my knowledge and belief.

Physician's Signature: \_\_\_\_\_ Date (MM/DD/YY): \_\_\_\_\_